Part B Insider (Multispecialty) Coding Alert

Clip And Save: Get A Grip on MAC Vernacular to Avoid Denials

Know these top acronyms commonly found in MAC coding and provider resources.

CMS utilizes Medicare Administrative Contractors (MACs)—private insurers by geographic region who process Part A and Part B claims—ensuring that providers in each state have a resource for questions and concerns. Some of the terms bandied about on contractor calls, webinars, and education portals as well as on the website can be confusing to coders, billers, and providers.

Part B Insider has compiled a short refresher list of acronyms to have in your back pocket when the system goes down or the audio flakes out. Here are the top ten acronyms commonly used to help you interpret your MAC's outreach:

ACT — Ask-the-contractor teleconferences, which are also known as ACTs, are mandated by the Medicare Modernization Act (MMA). These group chats organized by MAC outreach consultants assist both Part A and Part B providers with answers and advice to questions on a particular timely topic and are part of a CMS education effort on Medicare changes.

EOB — The Explanation of Benefits (or EOB) is a form that insurers send patients after they process a medical claim. Patients often mistake the EOB for a bill, but it is rather a detailed explanation of the claim and services rendered.

IOM — Internet-only Manuals (or IOMs) are defined by CMS as "a replica of the agency's official record copy." What that means is that IOMs cover the Medicare daily posts, rulings, policies, and updates to procedures and coverage—guidebooks for understanding CMS.

LCD — A Local Coverage Determination (or LCD) relates to MAC limitations placed on particular items and services under its distinct jurisdiction.

MSP — Medicare Secondary Payer (MSP) refers to the process of payment when Medicare is the second insurer after another entity who holds the primary payment responsibility.

NCD — National Coverage Determinations (NCDs) pertain to the nationally recognized information on a service or item, and there is usually only an NCD to follow when a MAC does not provide an LCD.

OCA — An OCA (or an Overpayment Claims Adjustment) happens when Medicare determines that a provider has been overpaid for care given. The OCA is the process that occurs to rectify the overpayment to be paid back to Medicare.

PTAN — A PTAN, not to be confused with an NPI, is a number distributed by MACs to providers upon enrollment and is for Medicare use only.

RA/ERA — Remittance Advice (RA) or the electronic version (ERA) is sent to providers after a claim has been submitted to the MAC. The RAs or ERAs are itemized and offer information about the payment and any adjustments made by Medicare.

SIA — Supplemental Instructional Articles (SIA) are coding guidelines that explain a service, LCD, or CMS coverage in more detail and cover an individual MAC's rule.

Resource: For a quick overview of MACs and the link to the complete and current lists to access more information, visit https://www.cms.gov/medicare/medicare-contracting/medicare-administrative-contractors/medicareadministrativecontra

ctors.html.